



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

PALO PINTO GENERAL HOSPITAL  
400 SW 25TH AVE  
MINERAL WELLS TX 76067-8246

#### **Respondent Name**

ARCH INSURANCE COMPANY

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-08-5143-01

#### **MFDR Date Received**

April 8, 2008

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "We eventually learned from the customer service representative that the whole claim denied for lack of start and stop times for anesthesia. Those times were enclosed. Under Texas Workers compensation rules, a carrier cannot deny the entire claim, only the portion that is problematic."

**Amount in Dispute:** \$6,562.99

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The billing in dispute has been processed in accordance with DWC guidelines, policies and rules, and the Texas Labor Code."

**Response Submitted by:** Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

### **SUMMARY OF FINDINGS**

| Date(s) of Service | Disputed Services            | Amount In Dispute | Amount Due |
|--------------------|------------------------------|-------------------|------------|
| October 12, 2007   | Outpatient Hospital Services | \$6,562.99        | \$0.00     |

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets a time limit for submitting medical bills.
3. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 29 – The time limit for filing has expired
  - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

## **Findings**

1. The insurance carrier denied disputed services with reason code 29 – The time limit for filing has expired. Per 28 Texas Administrative Code §133.20(b) effective May 2, 2006, 31 *Texas Register* 3544 requires that a health care provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date the services are provided. 28 Texas Administrative Code §102.4(h) states that “Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission.” The disputed date of service is October 12, 2007. The requestor submitted documentation to support that the insurance carrier received a completed facsimile transmission of the disputed bill on November 8, 2007. The fax receipt date is prior to the 95<sup>th</sup> day after the date the disputed services were provided. The insurance carrier’s denial reason is not supported. The disputed services will therefore be reviewed for payment according to applicable rules and fee guidelines.
2. This dispute relates to services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection §134.1(d) which states that “Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.”
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. Former 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:
  - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
  - The Division has previously found, as stated in the adoption preamble to the former *Acute Care Inpatient Hospital Fee Guideline*, that “hospital charges are not a valid indicator of a hospital’s costs of providing services nor of what is being paid by other payors” (22 *Texas Register* 6271). The Division further considered alternative methods of reimbursement that use hospital charges as their basis; such methods were rejected because they “allow the hospitals to affect their reimbursement by inflating their charges” (22 *Texas Register* 6268-6269). Therefore, the use of a hospital’s “usual and customary” charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
  - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
  - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
  - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

## **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

### Authorized Signature

|           |  |                       |
|-----------|--|-----------------------|
| _____     | <u>Grayson Richardson</u>              | <u>August 9, 2013</u> |
| Signature | Medical Fee Dispute Resolution Officer | Date                  |

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**